Welcome

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: _____

Name: _____
Last First Mi

Nickname: _____ ❑ Male ❑ Female
Birthdate: ___/___/___ Age: _____
School: _____ Grade: _____
College: _____ SS #: _____
E-mail Address: _____
Hobbies / Sports: _____
_____
Home Phone: (_____) _____
Home Address: _____
_____
City State Zip

Whom may we Thank for referring you? _____
_____
Previous / Present Dentist: _____
(Please Circle)

Last visit date: _____

Other family members seen by us with Birthdate:

Name	Birthdate
_____	___/___/___
_____	___/___/___
_____	___/___/___

Who is responsible for making appointments?

Name: _____ Relation: _____
Work Phone: (_____) _____
Home Phone: (_____) _____

Parent Information:

E-Mail address: _____
Who is accompanying you today? _____
Name: _____ Relation: _____
Does this person have legal custody of you? ❑Yes ❑ No
Parent's Marital Status: (Please Circle)
Single Widowed Married Divorced Separated Partnered

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/___
Wk Phone:(___)_____ Hm Phone:(___)_____
Employer: _____ SS #: _____
How long at current job? _____ Job title: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ___/___/___
Wk Phone:(___)_____ Hm Phone:(___)_____
Employer: _____ SS #: _____
How long at current job? _____ Job title: _____

Person Responsible For Account:

Name: _____ Relation: _____
Employer: _____ DL #: _____
Wk Phone:(___)_____ Hm Phone:(___)_____
Social Security #: _____
Billing Address: _____
_____
City State Zip
Previous Address: _____
_____
City State Zip

Primary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___ SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____
_____
City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? ❑ Yes ❑ No
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
City State Zip
Insurance Co. Phone #: (_____) _____
Group # (Plan, Local or Policy #): _____
Policy Owner's Name: _____
Relationship to Policy Owner: _____
Policy Owner's Birthdate: ___/___/___SS #: _____
Policy Owner's Employer: _____
Employer's Address: _____
_____
City State Zip

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